ELDER ABUSE: EVERYONE'S CONCERN

For additional copies, please write -

The Senior Citizens' Secretariat
P.O.Box 2065
Halifax, Nova Scotia
B3J 2Z1

ACKNOWLEDGEMENTS

There continues to be much scepticism about the incidence of elder abuse. Many Nova Scotians find it difficult to believe there are more than a few isolated cases. Others exaggerate the dimensions of the problem especially when institutions, such as nursing homes and hospitals, are involved.

The need for a comprehensive and well documented statement on the nature, extent and causes of elder abuse became apparent to the Secretariat in 1984. A summer student, David MacLennan worked on the project in the summer of 1984. Mrs. Margaret Snyder, a senior student at the Dalhousie School of Recreation, Physical and Health Education, joined the Secretariat for the summer of 1985 and did extensive work on this document.

John Angus MacKenzie, former Deputy Minister of Social Services, joined the staff of the Secretariat in January 1986 and the document which we are now releasing has been edited and substantially revised by Mr. MacKenzie.

We sincerely hope the material contained herein will be useful to Nova Scotians who are working with seniors or interested in their welfare. The source documentation has been drawn from the latest and best material available in the United Kingdom, the United States and Canada. The footnotes and bibliography give some indication of the extensive use made of such resources.

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INTRODUCTION

> Mrs. X., a 75 year old woman, was admitted to hospital with severe dehydration, malnutrition and numerous ulcers. She had to be soaked for four to five hours to lift the dirt from her body. Her hands had to be pried open and it was difficult to straighten her arms and legs. This woman lived with her elderly husband, her son, her daughter-in-law and their children. A few days after admission she died, a victim of gross abuse and neglect by her family.

There is a growing awareness about the victimization of the elderly. Some experts in the field of aging hold that elder abuse and crimes against the elderly should be dealt with separately. In this publication we have chosen to define elder abuse to include crime in the streets and in the home by strangers, maltreatment within institutional settings, fraud and deception, and abuse by informal care providers including family, friends and neighbours.

While only a relatively small percent of the elderly have been victimized, fear, anxiety and suspicion are fairly common reactions by an elderly person.

Unfortunately, victimization of the elderly is often invisible to the general public. Victimization can occur within homes, within institutions, on crowded and busy streets, and through the mail. Individuals are the victims - not large groups - and only periodically does publicity reach the

general public. There is no organized group of elderly victims of fraud, abuse, maltreatment and criminal behaviour who band together and demand justice and public action.

Child abuse emerged as a social problem in the 1960's and wife abuse was identified as a major social issue in the 1970's. Abuse of the elderly has become a concern of the 1980's.

Pederick - Cornell and Gilles[1] identify two major factors which they feel explain why the abuse of older persons became a focal point of attention in the early 1980's:

(1) The discovery of a significant number of elderly victims of family violence was a natural outgrowth of extensive research on the extent and patterns of family violence. By conceptualizing the problem as one of "family violence" and not simply "child abuse" or "wife battering" researchers have been able to identify varying patterns and incidence of violence in the family.

(2) Major demographic changes have occurred over the last half century which help explain why problems of the elderly and problems of elder abuse specifically have captured public attention. First, the life expectancy of the average person has increased by nearly 50% in the last fifty years. Second, as a consequence of this increased life expectancy and population increase

> in general, there are growing numbers of individuals 60 years of age and older. Third, the proportion of the population 60 years and older has increased.

Steinmetz, commenting on these demographic changes in the last quarter of the 20th century points out that -

> not only will one out of every eight persons be 65 years or older by the close of this century, but the greatest increase (53%) will be among the very oldest citizens, i.e., those 75 years of age and older.[2]

The typical member of this older population, according to Treas,[3] is likely to be a woman, a widow and very old.

According to Brody,[4] one of the myths of this society is that older people are being abandoned by their children to live in institutions or alone. Figures refute this belief. Bussman and Burchinal[5] conclude from their studies that as people age, they become more involved with their families than with non-kin or other types of activities. Puner,[6] Butler and Lewis[7] found that 80% of older people have living children and 75% of them live in the same household or thirty minutes away. Eighty percent of home care to the aged is given by family members residing in the same household according to Brody[8] and about one-third of these elderly persons need constant care of a medical or personal nature, not including food preparation and household maintenance chores.

In Nova Scotia only 6% of the population are cared for

in hospitals and in homes for special care, such as, nursing homes and homes for the aged.

These findings bear serious consideration in planning for our senior population. Adult children or family may expect to be providing a significant amount of care to an increasingly larger and older population. The chances that each of us may someday be caring for one of our parents are increasing, as is the likelihood that the parent will be quite old and perhaps quite frail. What will be the impact of these demands on the family as family resources (emotional as well as financial) become overextended, as women continue to enter the job market (lessening their ability and willingness to care for the at-home parent) and as family size continues to shrink (decreasing the number of adult children who can share responsibility for parent-care).

CAUSES OF ELDER ABUSE

Dr. Fox[9] argues that our society, through its rejection of the elderly as useful members of society and the rejection of the image of old age, in effect, abuses the elderly. Ours is a youth oriented society and the appearances of aging are disguised at all costs. In many respects the aged are perceived to be at the end of their economically productive life, which is the basis on which our culture values individuals and provides them with deference, status, respect and rewards.

Butler has coined the word "ageism" to describe this unwarranted prejudice against the elderly which pervades all sectors including the helping professions. In its simplest form, ageism is "just not wanting to have all those ugly old people around."[10]

Podnieks[11] like Dr. Fox and Dr. Butler, contends that the way we care for our elderly depends on our attitude towards aging. Young people are not the only ones who tend to regard the elderly as useless and obsolete: negative stereotyping of the elderly permeates our society today and health care workers in active treatment hospitals and extended care facilities are learning to be influenced by this prejudice.

Others, including Dr. Rathbone-McCuane[12], postulate that elder abuse, like child abuse and wife battering, is part of a family life and a society which continues to be characterized by violence.

Dr. Rathbone-McCuane and Barbara Voigles, a social

worker, argue that

> violence is America's sweetheart, but the elderly are not, and they pay a heavy price as victims of societal neglect and blatant discrimination.[13]

In essence, negative stereotyping of seniors; ignorance or overwork on the part of the care givers; lack of self-worth; financial greed; alcoholism and drug abuse; personality problems of the care givers; and, the dependency of the seniors involved, all seem to play a part in individual cases of elder abuse.

Current theoretical hypotheses for the causes of elder abuse are fourfold and include: theories that emphasize the pathological nature of the care giver; those that focus on the stresses of caring for the often impaired elder; closely related theories that look at the dependency of the elder victim as a powerful potential trigger; and, those that view the above as part of a pattern of trans-generational violence.

According to Pratt, Koval and Lloyd[14] the stress of parental dependence, a family history of violence, inadequate resources and social norms that legitimize violence, all contribute to the neglect and abuse of the elderly.

Elaine Walsh, a member of the Board of Directors of the New York City Chapter of the National Association of Social Workers in her presentation to the U.S. Congressional Hearings in 1980 identified violence in the family as the single most significant factor in elder abuse. "The abused child becomes the abuser when the parent is placed in the dependent role",[15]

Ms. Walsh stated.

As well, according to Ms. Walsh,[16] societal pressures, mainly economic, play an increasing and insidious role in abuse. Inflation and rising unemployment together with a severe lack of support services for children taking care of elderly parents place such children in an emotional pressure cooker. Most of these children want to care for their parents but the tensions overwhelm them.

A study by Hickey and Douglass,[17] based on case experiences of professionals who deal with elderly persons on a regular basis, reports that most respondents attributed multiple and often overlapping causes to the problem of elder abuse. Explanations for the abuse of elderly persons included the pathological behaviour of the abuser and the dependence/vulnerability of the elderly person; the family's history of violent patterns of behaviour over several generations; and, irrational reactions to life-crises.

Studies by Stein and Austin, Brennan, Rathbone-McCuane and O'Malley[18] all suggest that alcoholism of the care giver(s) is associated with elder abuse.

Hickey and Douglass[19] and Steinmetz[20] found that the sudden and unwanted dependency of a parent and the autonomy and private nature of the family provide an environment for mistreatment and are key factors in understanding neglect and abuse. The dependent elderly person can be a source of emotional, physical and financial stress to the adult children who may be unprepared or unable to assume these responsibilities.

Some families may become overwhelmed by the constant supervision they may be called upon to provide and the lack of support services to assist in the care of the aged person.

Dr. Thompson commenting on the pressures on care givers states -

> Violence against the elderly occurs in those often with the best motives, who also have strong emotional ties with the recipient. Unfulfilled expectations, fatigue, isolation, and reversal of caring roles produce intolerable strains in carers, and pent up emotion becomes directed blindly at the aged victim first by verbal tirade, and then by physical assault.[21]

According to Hickey and Douglass[22] the most critical factors associated with abuse are the care giver's lack of ability or disinterest in responding to the needs of vulnerable family members and their unwillingness to accept the dependency relationship of an older adult.

Research by Anderson,[23] Steinmetz[24] and Lau & Kosberg[25] suggest that many family members caring for elderly persons are themselves likely to be elderly and the increasing strain placed on them may provide a situation conducive to potential abuse.

Steinmetz[26] and Burston[27] conclude that the emotional and financial burden of caring for one's older parent(s) may be a precipitative factor in elder abuse. Brody,[28] Tuzil and Johnson[29] and Bursk[30] provide some support for this conclusion in their analysis of the aging family.

Bookin and Dunkle provide the following summary of relevant variables to be explored by practitioners in investigating elder abuse.

Vulnerability/Dependency of Elder/Ageism	Family Value System What is family's attitude toward the elder? What is family's attitude concerning the elder's dependency? Is there evidence of financial exploitation/violation of rights?
Learned Patterns of Violence/Unresolved Family Conflict	Family's Past History of Coping with Problems How has family dealt with problems in past? How do members generally resolve conflict? Is there evidence of long-standing unresolved family conflict? Environment of Home Could it support use of force or violence? What are the present sources of stress affecting family? Developmental Stage of Family Is family able to accommodate needs and demands of family members? To what extent? Is excessive stress generated in process? How does family system respond to stress?
Stress of Caregiving	Care Needs of Elder Are they extensive? Is a great deal of stress generated as a result?
Lack of Family Supports	State of Family Supports If these are lacking, is this a short-term or long-term situation?

	Do other family members live within reasonable proximity but are not involved? Is there or has there been present or previous service from other social service agencies?
Pathological Symptoms	Pathological Symptoms Is there evidence of pathological behavior of a family member, such as mental illness, alcoholism, or drug abuse? 31

Dr. Roy Fox summarizes the predisposing factors to elder abuse as follows:

a) Care provider strain
The kind of strains that the care providers are subjected to centre around the basic physiological functions. Incontinence of urine is an example, and this is hard to live with if not managed well. There may be burdens of washing, of spending money on aids and of living with the smell. Add to this incontinence of feces when visitors are present, for example, and the stresses build.

The elderly person may be struggling to maintain continence, and succeeding, but needs to get up at least four times at night. A fall to the floor in the middle of the night might lead to the care provider arising four times a night as well. Loss of sleep is devastating, as any mother will testify.

The sleep disturbance may be brought on by confusion, due to senile dementia. Nights are the worst times for such patients. There is frequently no awareness of night or day and a relative rising at 2 a.m. to start the day can be very disruptive.

With the mental and physical frailty come personality changes. The care providers may feel that they are not caring for the same person that they have known all their life. A once respected and lovable person becomes dishevelled, and verbally and physically aggressive. It may be that aggression may be instigated by the victims, but it then escalates.

On top of these strains, there may be physical strain when the patient is physically frail and lifting is required. For some care providers, the strain is too much.

b) Dependency (The ill elderly)

Dependence is related to aging of the various systems in the body, and the onset of multiple pathologies.

For example, there is aging of various parts of the nervous system which contributes to deterioration in balance and in gait. Thus, walking may be more difficult, becoming slower with a tendency to fall. This can be added to by deterioration in vision and other senses. Perhaps the situation is compounded by the presence of diseases such as osteoarthritis and cardiac failure.

An additional burden, such as chest infection or anemia, changes the person from being acceptable but dependent, to being too dependent and unacceptable. At this critical time in their life, they may be helped or made worse. Unfortunately, not enough are helped and too many are made worse. Too many are abused.

Abuse occurs if no one recognizes that dependency can be alleviated by the correct medical treatment. Abuse results if the physician practices ageism. As a result of ignorance the new illness is not recognized and the increased dependency is "managed" by referral to a social worker. The medical problems are "treated" socially - an illogical and tragic state of affairs.

c) Lack of resources

Alternatively, the elderly patient may be forced into care in inferior housing with limited resources. This is abuse by being denied access to the best and most appropriate treatment which would be available in a fully equipped general hospital. Support services may be few and when they are present, are too often insufficient to meet the demands, or too expensive. Even options that are available are often not known of by family or care providers. In these settings, families may struggle on for many months with the stress and strain building on them, the care providers.

The cost of care usually influences decision and it may well be advantageous for a family to care for their elderly relative at home rather than in a more appropriate setting. This incentive does not protect the care provider from stress and strain. As time passes and stress mounts, it may reach a critical breaking point, and when it does, elder abuse is most likely to occur.

d) Family factors

Sometimes the care providers are inappropriate and they are unable to control themselves. For example, they have waning intellectual capacities themselves or they may be alcoholic.

The family member who abuses may have had a bad relationship of longstanding with the abused. The victim may have been a harsh disciplinarian as a father, and here, at last, is a chance to get even.

Abuse may be fired by frustration and anger. The elderly dependent relative suddenly frustrating a family's goals to the point where they see no hope and no way out.

The emotions that such a family may experience are many. The resentment and begrudging acceptance are common. There may be envy, to the extent that the elder is receiving such good care and is living in the lap of luxury.

Finally, the need to provide care in this situation may bring with it an acute awareness of the aging process. The carers see themselves 20 or 30 years down the road. It is not a comforting sight.[32]

Chen and Bell summarize the causative factors of elder abuse as follows:

Situational:
*elderly is a vulnerable target/scapegoat being dependent, isolated, powerless and not being able to fight back, in poor physical health and with diminishing physical functioning, increased dependency.
*lack of social and emotional support system: lack of contacts with family members or significant others.
*poverty/financial stress
*poor housing/neighbourhood/community
*lack of options for elderly to turn to should they expose abuser(s)
*unemployment of abuser
*substance abuse of abuser

Societal:
*inadequate available resources, social services and social planning system
*lack of skills of practitioners to help
*lack of confidence in social services/programs/bureaucracy
*lack of committment, concern for the elderly
*public negative attitude about aging process
*stereotyping of elderly
*lack of worth of elderly as productive members
*elderly of low societal priority
*changing societal mores and values
*societal values too materialistic
*insensitive institutions/nursing homes/day care for the elderly
*little or no consistent community support

*insufficient follow-up by service practitioners
*lack of safety measures in the environment
*little consumer input in programs for the elderly
*ignorance of legal rights of the elderly
*ignorance of the aging process
*learned helplessness of the elderly.

Family:
*family stress or crisis
*long standing poor family inter-relationships, or feuds especially between elderly person and caretaker
*family pathology/disintegration due to breakdown of nuclear family pattern
*multiple family problem: economic, housing, interpersonal relationship, marital, desertion
*marital conflict where abuser is the spouse
*changing roles, role reversals, unrealistic expectations of role fulfillment
*family life style includes pattern of violence, violence/cruelty accepted as norm in family: intergenerational violence cycle
*unreasonable demands on abuser by abused and vice versa
*control and mismanagement of family assets/financial gain
*issue of power/generation gap
*alienation from sources of help
*decision-making without elderly person's participation.[33]

NATURE, TYPES AND EXTENT OF ELDER ABUSE

NATURE

Elder abuse may be defined as any act of commission or omission directed towards an elderly person in a manner that is detrimental to his or her health and/or wellbeing.

Chen and Bell[34] in their study defined abuse to include abusive actions inflicted by abusers on adults sixty years of age or older including -

Physical abuse - the non-accidental, willful infliction of physical pain or injury, physical neglect, deprivation of nutrition.

Psychological abuse _ emotional harm, mental anguish, unreasonable confinement and emotional neglect.

Sexual abuse - rape and attempted rape.

Social/Environmental abuse - the deprivation of human services, involuntary isolation and financial abuse.

Giordano and Giordano[35] identified six categories of elder abuse including -

Physical abuse - violence that results in bodily harm or mental distress, eg., assault, unjustified denial of another's rights, sexual abuse, restrictions on freedom of movement and murder.

Negligence - breach of duty or carelessness that results in injury or the violation of rights.

Financial Exploitation- theft or conversion of money or objects of value belonging to an elderly person by a relative or caretaker. It can be accomplished by force or through mis-representation.

Psychological Abuse - provoking of fear of violence or isolation, including name calling and other forms of verbal assault and threats of placement in a nursing home. It can be a spontaneous or protracted and systematic effort to dehumanize and usually is accompanied by other types of abuse.

Violation of Rights _ The breaching of rights that are guaranteed to all citizens by the Constitution, federal, provincial and municipal statutes.

Self-neglect - includes self-inflicted physical harm and the failure to take care of one's personal needs. It stems from the elderly person's diminished physical or mental abilities and is brought on by the attitudes and behaviour of relatives.

The Manitoba Study[36] defined elder abuse to include physical, psychological and financial abuse -

Physical Abuse - includes situations involving physical assault, rough handling causing physical injuries or discomfort, injuries or gross neglect caused by others, avoidance of needs for assistance and the withholding of physical necessities such as food, personal and hygenic care or medical care.

Psychological Abuse - includes confinement, isolation, inadequate attention in terms of time, concern and understanding of needs, and the removal from active participation in one's own life. This category also includes verbal/emotional abuse such as humiliation, intimidation, derrogation, infantalization or any other treatment of the elderly person which diminishes his/her identity, dignity or self-worth.

Financial Abuse - defined to include situations relating to money matters and may involve the withholding of finances, trickery,fraud, theft, misappropriation or misuse of funds or property. This form of abuse may involve the withholding from the elderly of the means for daily living necessities.

TYPES:

HOME

Increasingly seniors are being encouraged and supported to remain in their own homes and communities.

Skanas[37] in a survey in 1979 found that increasingly families are providing long-term care for the elderly rather than placing them in institutions. Indeed,there appears to be a growing trend toward the rejection of nursing homes and long term care facilities for the aged and an increasing number of

families are becoming involved in the care of their elderly members.

Estimates from various sources would suggest that at least 90% of seniors are remaining in their own homes or the homes of family or relatives and existing studies focus almost exclusively on elder abuse in private homes.

Lau and Kosber[38] found that over 75% of elder abuse at home involved physical abuse and over 50% involved psychological abuse. Other forms of abuse included misuse or theft of money or property, being forced from home, or being forced into a nursing home. They also found that the elderly person often suffered from more than one form of abuse.

Sengstock and Liang[39] found that 20% of the cases involved physical abuse; 23% of the cases involved physical neglect; 55% of the cases involved financial abuse; 23% of the cases involved psychological neglect; and, 50% of the cases involved psychological abuse. Many cases, they found, involved more than one type of abuse and more than a single incident of abuse.

These findings are supported by the Manitoba Study[40] which found financial abuse most prevalent followed by psychological and physical abuse.

Paul Girard, Director of the Social Services Department, Victoria General Hospital contends that -

> The motivating factor which underlies all cases of elder abuse is that the perpetrator realizes or believes that there is some quantifiable monetary gain in cash or in kind either on an ongoing basis or as an outcome of death.[41]

INSTITUTION

We have very limited knowledge of the extent of abuse in nursing homes, homes for the aged, boarding homes, hospitals or other non-profit settings although it is reasonable to assume that abuse, to the extent it may exist, is largely the result of neglect or the requirements of institutional living rather than overt actions aimed at endangering the health and/or wellbeing of the elderly person in care.

Dr. Fox, speaking to the problems experienced by elderly persons in institutions identified the following areas of concern:

> Lack of privacy resulting from forced sharing; abuse of other residents, eg., roommate; poor medical treatment and help; limited recreation opportunities; loss of lifetime possessions; loss of dignity; lack of meaningful activities or the opportunity to engage in them. The elderly person's right to privacy is taken away, their comings and goings and all activities are available for supervision and censoring. The elderly may also find they have no control over anything any longer. With loss of control comes loss of will and the last vestiges of human dignity and self-respect. The beginning of the final deterioration. [42]

Elder abuse or neglect in institutions, when it does occur, is usually related to inadequate personnel policies, practices or management. If there are insufficient personnel and/or inadequately trained personnel, elderly residents may be over-medicated to keep them quiet or only have one aspect of their care requirements met. The preponderance of staff in nursing homes, homes for the aged and boarding homes are personal care workers whose primary concern is the physical

care of the elderly residents, i.e., making beds, washing and dressing the elderly, etc. These staff have precious little time in their daily routine to sit and talk to the residents, to share their joys and aspirations, and to allay their fears. In the same vein these staff, because of other demands,are often not available to those residents who need help and encouragement to eat, not because they can't eat, but simply because they have lost the will to eat. The elderly residents' physical needs may be met but in many instances their social and psychological needs do not receive adequate attention.

Problems may arise when elderly residents become chronically ill and are no longer able to protect their personal interests. Unless there is a family member willing and available to intervene, the senior is completely at the mercy of the institution. In such situations the elderly resident becomes an easy mark for dishonest personnel who, on getting control of the senior's property and assets, proceeds to siphon off as much as possible for personal use.

There have been a number of situations reported over the years where the primary interest of even family and relatives of elderly residents has been the residents' monthly comforts allowance.

Podnieks in discussing elder abuse in active treatment hospitals and extended care facilities identifies a number of actions by professional staff which she contends go almost unnoticed and yet are as deplorable as more violent acts of

mistreatment.

> For example, I am a highly skilled technical nurse working in a specialty area. Do I feel hostility toward the "geri-patient" who is waiting for a bed in an extended care facility?
> Do I sometimes show these feelings?
>
> Do I resent having to feed an elderly patient and, because of this, rush her just a little? Do I stand instead of sit, not making any conversation? Does my face reflect my impatience to be finished with this task?
>
> Do I ever tie the restraints more tightly than necessary, or do I sometimes sit with a patient so that the restraints can come off for a while?
>
> Am I slow to answer the call bell because I know that patient needs the bed pan - again?
>
> At report do I pass over a patient with the comment that: "She's still waiting for placement".
>
> Do I question the doctor who orders so much sedation for an elderly patient?
>
> Do I respect my patient's right to privacy?
>
> Do I turn my feeble patients and keep them well hydrated, or do I simply chart "refuses to drink"?
>
> Do I watch for any signs of mistreatment by the patient's family or other caregivers?
>
> Am I meeting all my patient's health needs but ignoring things like his need for love and belonging?
>
> Do I sometimes, with the best of intentions, deprive my patients of their independence, their right to make choices and decisions?
>
> How often are my patients' rights violated by endless physical examinations, even to the point of medical students using older patients to practice cardio-pulmonary resuscitation? [43]

A degree of caution is warranted, however, in assessing group care living arrangements for the elderly. Rural boarding homes caring for two or three old age pensioners may seem woefully inadequate to the sophisticated urban professional,

when in reality they are consistent with the lifestyle of the senior.

STREET CRIME

Today's seniors are products of the depression years, which had a profound psychological effect on their attitudes toward money and material things.

Many of these seniors were not accustomed to using banks in their earlier years and continue to keep large amounts of money on their person or in their homes.

These bad habits provide a fertile field for the perpetrators of street crime.

Petty criminals looking for an easy mark identify seniors as obvious victims. They make it their business to learn when pension cheques are being delivered in the mail and hang around seniors' housing ready to steal from the mail boxes or grab the seniors' purse when they leave the bank. The elderly person with a purse or jewellery is a ready victim for the street criminal who picks on the weak and the vulnerable in our society.

In the same vein many seniors have grown up in safe, trusting environments where it was a way of life to leave the house open, to answer the door and to invite strangers inside. In large measure these practices have changed in the cities and towns, if not in the country as well. Petty household theft, occasionally resulting in serious bodily injury, if not murder, is not uncommon.

The Subcommittee on Housing and Consumer Interests of the U.S. House Select Committee on Ageing[44] conducted a survey of chiefs of police in 50 cities in 1978 and found that the elderly had higher victimization rates for the following crimes: pedestrian robbery, swindling, break and entry, purse snatching, muggings, con game artists, commercial fraud, medical quackery, insurance fraud and high pressure sales schemes.

Constable Logan[45] of the Halifax Police Department, in a survey of two areas of the city, found that 22% of seniors who had been victims of such crimes did not report them for a variety of reasons including fear, the feeling that it was their own fault and/or that nothing could/would be done.

FINANCIAL EXPLOITATION

There is always a small segment of any society who spend their life planning schemes to exploit the unwary, the vulnerable, the gullible and the greedy members of society. Seniors, being more trusting and less suspicious than the general population, are prime targets for this type of exploitation. The schemes that surface under this heading are a tribute to the ingenuity of the crooks and include home repair and improvement frauds, contributions to religious organizations, medical frauds, the bank examiner fraud, and various mail frauds.

Of these, the "bank examiner" fraud is probably the most ingenious. The elderly are approached near their banks by a

well-dressed person posing as an official of the bank. Through a series of deceptions, the senior is conned into believing that a teller in his or her bank is suspected of stealing. The "bank examiner" proposes that the senior withdraw a large sum of cash in previously marked bills from that teller, then give the cash to the "bank examiner". He tells the senior he will check out any irregularities in the sequence of the bills, guarantee the money will be redeposited into the senior's account later, thanks the senior for his or her cooperation and disappears with the money, never to be seen again.

Financial institutions having control of a senior's savings may also be the instruments of abuse by failing to invest such savings in a manner which ensures the best possible return on the senior's investment. In fact, cases have been reported where a senior's life savings have been invested by financial institutions in a manner which ensures the institution the best return at the expense of the senior citizen.

Seniors are susceptible to chronic ailments and it is estimated that sixty per cent of all medical quackery is targeted at the elderly. Medical frauds may include selling over-priced hearing aids to seniors who do not need them and phoney cures for prostate ailments, glaucoma, arthritis and cancer. In such frauds, the con artists are selling hope - hope for the relief of pain, restoration of health/youth and delay of death.

Since most seniors live in the community, either with

relatives or in their own homes, con artists use a direct approach to homeowners in the community. After using a phoney identification to gain entry, the con artist may discover a major flaw in the wiring or plumbing. The con artist undertakes to convince the senior that work must be done. If successful the job is completed with second-rate skills and materials and the bill is inflated out of all reason.

Another popular home repair fraud is the chimney repairman. He may attempt to convince the senior that he noticed a flaw in the chimney while driving by; he has some extra materials in his truck; and, he will give the senior a "special deal". If the senior goes along with the con,the completed job most likely was unnecessary and poorly done.

In many respects the financial abuse of seniors is more subtle and more difficult to control than physical and mental abuse. The possibilities range from regular and methodical scrounging of the senior's pension cheque or comforts allowance (if in an institution) by family members, to more serious financial irregularities involving sizeable property holdings and other assets. Close family members may, and often do, behave in a most predatory manner in respect to advising and assisting their father, mother, brother, sister, grandfather, or grandmother in respect to the disposition of assets such as property and money.

A few religious sects work on the fears and hopes of the elderly with all sorts of tear-jerking schemes to pry loose

money from the unsuspecting.

Street crime in which chronic and habitual criminals lay in wait around banks and seniors' housing units to snatch purses is an increasing menace in spite of the best efforts on the part of the police to protect the elderly.

SELF-NEGLECT

Giordano and Giordano[46] include self-neglect in their six categories of elderly abuse which they define to include self-inflicted physical harm and failure of the elderly person to care for his/her personal needs.

While the data with respect to the prevalance of self-neglect on the part of elderly living in the community is not readily available, there is every indication that a significant number of seniors are living out their declining years in conditions of neglect brought about by increasing senility and inability to care properly for themselves.

Examples of self-neglect include the senior living in an isolated community in a shack or trailer, sometimes hoarding pension income, and in danger of freezing or starving to death; the elderly woman living alone and becoming more and more senile and unable to provide self-care, yet unwilling to go to a nursing home or bring in a caregiver from the community; and, the eccentric elderly person who will brook no outside interference with his or her lifestyle and who becomes progressively more and more senile and unable to provide even a minimum degree of self-care.

EXTENT

Estimates of the extent of elder abuse vary considerably, although studies from a variety of sources indicate that elder abuse is at least as widespread as child abuse, and is on the rise; and, that there is a high correlation between a high level of dependency in the elderly person and abuse by the care giver. American research, which is by far the most extensive, would suggest that 10% of the dependent elderly living with family/relatives are abused each year and that the incidents of abuse tend to be recurring events, and not single occurrences. Eastman and Sutton[47] adopting the 10% figure and applying it to the U.K., where 42% of over 65 year olds are supported by care giving relatives, estimated that 500,000 elderly people may be facing emotional trauma, physical pain and/or financial exploitation. The only major study of elder abuse in Canada was carried out in Manitoba as a joint project by the Manitoba Association of Gerontology and the Manitoba Council on Aging in 1982. This study found that

> 2.2% of the 18,000 elderly persons receiving care from informal care providers or home service agencies had experienced abuse of some kind at the hands of caregivers, 93% of whom were family members.[48]

This study goes on to suggest that as with other forms of abuse, eg. child abuse, the cases reported represent only the "tip of the iceberg", a conclusion supported by Thorman[49] in his book on Family Violence.

In 1985 Haley[50] completed a province-wide survey of the nature and extent of elder abuse and neglect in Nova Scotia.

The findings of this survey would indicate that the incidence of abuse and neglect of seniors ranged from 1 in 400 to 1 in 1,000.

CHARACTERISTICS OF ABUSED AND ABUSER

Elder abuse in the home is frequently difficult to detect because of the relative isolation of its victims. Maltreatment is usually discovered only in routine visits by community service professionals.

As with other victims of family violence, abused elders are unlikely to report the abuse. They fear being abandoned or placed in an institution; they fear reprisals or the stigma of reporting a son or daughter; they may not know whom to tell; or, they may have some mental or physical impairment which prevents them from reporting the abuse. Dr. Rathbone-McCuane,[51] a Professor of Social Work at Washington University in St. Louis contends that for the elderly to admit they are abused by a loved one or other care giver on whom they may be totally dependent, is hard, even shameful.

THE ABUSED

There would seem to be general agreement that most abused elderly are not able to live independently. They must rely on their abuser to provide shelter, financial resources and/or day to day care. Often they have some degree of physical or mental impairment. As the majority of Canada's elderly are female, most of the victims are women and, in particular, women over the age of 75.

According to a national survey completed by the U.S.

House of Representatives[52] the victim is most apt to be a white female, 70 years of age or older, with moderate to severe physical or mental impairment.

Chen and Bell[53] describe the victims of abuse as mostly white females, between 60 and 80 years of age, widowed or single, of low socio-economic status, of less than high school education, of low income and not restricted to any ethnic or racial group.

The Legal Research and Services for the Elderly Organization of Massachusetts[54] found the typical abused elder to be a severely disabled, middle class woman over 75 who is psychologically mistreated by her relatives.

Stener and Austin,[55] as a result of their study, concluded that the elderly victims were frail women between the ages of 73 and 86, with physical and/or mental disabilities which made them dependent on the care giver for nutrition, medication, cleanliness, ambulation and in extreme cases, bed care. These findings are supported by Lau and Kosberg,[56] Rathbone-McCuane,[57] and O'Malley et al,[58] the latter concluding that in 63% of the cases of abuse identified, the elder victim was a source of stress to the abuser, primarily because the elder required a high level of physical or emotional care from the abuser, such as personal care, meal preparation and administering medication, or was financially dependent on the abuser.

Ferguson's[59] research concluded that abused elderly

tended to be 75 or older, female, white, currently not married, usually living in a private house or apartment and not destitute.

Filbee[60] in a study of elder abuse in Nova Scotia carried out in 1981 found abusers are generally children of the victim or a close relative with ages ranging from 23 to 65. They were often of low socio-economic status and blue collar workers. Maynard and MacMillian[61] of Nova Scotia disagree with this latter finding, stating that many affluent families tend to hide or institutionalize their frail aged parents.

Maynard and MacMillian[62] found those seniors most at risk are vulnerable due to advanced age, frailty, chronic disease, physical or mental impairment. They generally have two or more ongoing physical disabilities; are predominantly female; and, widowed. Although often of low socio-economic status, abuse is not restricted to any ethnic or social background.

Belanger of Quebec[63] in his survey of personnel working with the elderly found that 75% of those surveyed stated that the 60 to 79 age group were most often the victims of acts of violence.

The findings of a recent province-wide survey completed by Haley[64] would suggest that elderly persons 70 to 75 years of age living at home with a child or children are most at risk of neglect or abuse.

THE ABUSERS

The Abusers are almost always family members. Adult children or the spouses of adult children are usually the abusers of older people. Other relatives, including a spouse and unrelated care givers, may also mistreat the elderly.

According to a national survey completed by the U.S. House of Representatives[65] the abuser most commonly was a relative - daughter, son or spouse - residing with the elderly victim.

In 1978 the Baltimore City Police Department reported 149 assaults against older individuals, two-thirds of which were committed by relatives other than spouses.[66]

Littleton[67] maintains that adult children who abuse their parents were most likely abused as children but Renvoize[68] disagrees, arguing that most families who abuse an older member do not have a history of previous abuse.

Chen et al[69] describe the abusers as mostly white males between the ages of 40 and 60, single or married, of low socio-economic status, with less than high school education, mostly in blue collar occupations and encompassing a variety of ethnic and social groups. The abuser was in most cases the dependent's own adult child, a spouse, a grandchild or close relative, such as, a sibling or nephew.

Steinmetz[70] suggests that most abusers are women since they comprise the overwhelming majority of care givers; the care givers may also experience violence from their dependent parents

and, violence is often the method used as a last resort when it is perceived that nothing else will work.

Sengstock and Liang[71] found that the abuser was a child in 50% of cases with sons and daughters likely to be equally responsible. Sons were more likely to engage in direct abuse, both physical and emotional. Daughters were most likely to engage in psychological assault and in more indirect forms of neglect. They also found that the abused and abusers are often from multi-problem families which have suffered a great many difficulties in the past year.

According to O'Malley, Segars et al,[72] almost 75% of the abusers were experiencing some form of stress such as alcoholism or drug addiction, a long term medical complaint, or long term financial difficulties.

Edward Ansello, Associate Director of the University of Maryland's Center on Aging, which carried out an analysis of 50 major studies on elder abuse, concluded as follows:

> The picture that emerges is one of an over-burdened and unmarried son or daughter who has taken on the care of an elderly person. Far too often the caregiver may be too old or too disabled or too lacking in knowledge to provide adequate care.[73]

CASE PROFILES

The following cases of abuse and neglect have been brought to the attention of the Secretariat over the past five years.

CASE 1

Mrs. A. was admitted to the hospital with a fracture of the right wrist, two badly blackened eyes and bruises on various parts of her body. Living accommodation was with her husband in a senior citizens' housing facility. Mrs. A. adamantly denied any abuse, instead, insisting that she had fallen at home. Upon discharge, she returned to her home. Her family physician and the community health nurse were informed of the suspected abuse.

CASE 2

Mrs. B., an 81 year old woman was admitted to the hospital with severe ulcers on her legs that were found to have maggots in them. She lived with her older sister and two grand-daughters. There was evidence of neglect, financial and verbal abuse, as well as, suspected physical abuse from the grand-daughters. Though both seniors were mentally competent, they refused to admit there were any problems. The patient insisted on returning to the same environment. Follow-up care was provided by the family doctor and the VON.

CASE 3

Mrs. C., a 58 year old border line mentally competent female, was having difficulty caring for herself. Two adult daughters regularly stole their mother's monthly cheque and

spent it on themselves leaving her without food or money in a small, inadequate, filthy home. The municipality assumed responsibility for her cheque in trust and provided homemaker services for over one year. Three times she was offered a placement in a licensed boarding home and three times she refused. The case is still problematic.

CASE 4

Mrs. D., an 81 year old woman, lived with her son, an unemployed accountant with a known drinking problem. She was brought to Emergency in a confused mental state and described as "dirty, unkempt...excoriated areas under ventral hernia, urine burns on buttocks...candida on excoriated areas... long dirty fingernails." The care giver did not apparently supervise the patient's diet or ensure the provision of adequate personal care.

The patient's son admitted to occasionally going away for days at a time and relying on a niece to look in on his mother during those times. He had rejected any type of community services including VON, which was initiated after a previous admission.

The estate of the person was given over to the Public Trustee; the son was confronted with the fact that he could not provide adequate care; and, Mrs. D. was placed in a nursing home. The son now visits only when he is sober.

CASE 5

Mrs. E., a 75 year old woman, lived with her son, an obese, active alcoholic, living on disability pension. On admission she was very dirty and severely emaciated. It was concluded that she received inadequate personal care and nourishment. While in hospital her appetite improved, however, she remained confused and disoriented much of the time. She insisted on returning home.

The son admitted to difficulties in regard to managing his mother at home because of her unwillingness and inability to co-operate. At home he claimed that she had a poor appetite and refused to eat.

The patient was declared incompetent and the trusteeship of the estate was taken from the son and put in the hands of the Public Trustee. The patient was able to convince the discharge planners to place her at home with home supports and VON visits. However, it appears that the plan is not viable because the son will not co-operate, is drinking heavily, and is refusing to allow community supports to come into the home.

CASE 6

Miss F., a 92 year old woman, lived alone for the past 20 years in a rather expensive highrise apartment building in Halifax. Her care giver was a friend who lived in a nearby apartment. On admission she was described as needing

a hearing aid, teeth, proper nutrition and clothing. She had infected feet due to neglect of her toe nails, corns and was very dirty. The apartment was visited and was seen as dirty, e.g., no soap to wash pots and pans, the stove and kettle were out of order, etc.

The care giver had trusteeship of her estate. When asked about the lack of personal requirements, the trustee stated that she needed to save Miss F.'s money. As well the trustee refused the provision of services and was unwilling to have people enter the apartment.

The patient was not declared incompetent but trusteeship was taken from the friend. The patient returned to her home situation with a full home support program.

It was alleged that the patient's good furniture was taken by the care giver and that the care giver was the benefactor in the will.

CASE 7

Mrs. G., an 82 year old widow, lived in her own home with her granddaughter who was described as being mentally slow. The patient came to hospital dehydrated and with bed sores on her coccyx. A VON report strongly suggested that the patient required far more nursing care than she was getting. The care giver requested the VON come less frequently. Another relative reported that just eight months prior, Mrs. G.'s sister died of what he believed to be neglect from the same care giver.

The granddaughter admitted that physically the patient was too heavy to turn and that she did not want to spend the money as she would need the money to live. It was alleged that the care giver would not give the patient food or drink because the patient had no bowel control and she did not want to clean the mess.

The patient was declared incompetent and referred to the Public Trustee. She was discharged to a nursing home as a private paying resident.

CASE 8

Mrs. H., an 83 year old woman, lived with her son in her own home. The son was unemployed and a well known alcoholic who bootlegged from his mother's home. He also had a criminal record that included violent crimes. The patient came to hospital with a black eye, was dehydrated and had bed sores. Once the patient was admitted other family members stated they felt intimidated by the care giver and, therefore, never came forth but several other daughters described the home situation as "unsafe". The patient was widowed for several years and was a heavy drinker in the past.

The care giver explained the black eye by saying his mother was having "spells" and she often fell down; and, he described her lack of hygiene and care as a one time thing.

The son did not maintain contact and throughout her hospitalization the patient remained very confused.

The patient was declared incompetent and the trusteeship of the estate was taken from the son and put in the hands of the Public Trustee. Another more reliable son was given guardianship but found home care too difficult and he is now trying to find a suitable nursing home. The patient's house has been sold and the monies will be used for her care.

* * * * * * * * *

These case examples lend support to the literature on a number of counts:

- the victim in all cases was a single female, over 75 years of age and dependent on the care giver because of one or more disabilities;
- in all but one case, the presenting problem was one of neglect related to poor hygiene and nutrition - one case involved physical abuse;
- the pattern of neglect and abuse was well established and not an isolated incident;
- in most cases the abuser was a family member or relative;
- alcoholism was involved and/or limited functional ability which limited the care giver's ability to look after the elderly person; and,
- in each case the abuser stood to realize a financial gain.

Sanders and Plummer summarize the profiles of the victim and the abuser and suggest a close match with these profiles is reason to pursue an investigation.

TRAITS SHARED BY VICTIMS AND ABUSERS

- History of physical and/or mental illness.
- Low level of tolerance, easily frustrated.
- Dealing with anger or stress by striking out verbally or physically.
- Feelings of shame, guilt, hopelessness, or helplessness.
- Rejecting help from community resources or others outside the family group.
- Difficult and uncooperative personalities.
- Substance misuse, often actual alcoholism or drug addiction.
- History of attempts to control behavior of family members.
- "Shopping around" from hospital to hospital to avoid recognition of abusive situation.

INDIVIDUAL TRAITS

VICTIM	ABUSER
° Was a child abuser.	° Was abused as a child.
° Lifestyle disrupted by increased need for care.	° Lifestyle disrupted by having to provide care.
° Sudden increase in dependency because of need for physical care.	° Realization of inability to provide adequate care; constant fatigue.
° Increase in demanding behavior and physical complaints.	° Increase in anger and decrease in self-esteem.
° Adopts role of child.	° Resents role of parent.
° Needs to claim portion of house as personal space.	° Must give up or reduce space to accommodate parent.
° Decreased willingness or ability to make financial contributions.	° Increased financial burden; inability to meet expenses.
° Has few visitors to provide social interaction.	° Has little leisure time for friends or activities.[74]

PUBLIC PERCEPTION OF ELDER ABUSE

Eastman,[75] writing of his fourteen years as a social worker with the aged contends that society has not come to terms with the possibility of elder abuse. The common perception even among professionals, is that old people are to be honored and cherished in return for their years of toil and hardship in raising a family. There is something unnatural about abusing old people and the fact that a relative does the abusing is quite beyond our understanding. This viewpoint is supported by the work of Camille Jeffers,[76] Director of the Elder Abuse and Neglect Project in Atlanta, who found that people just aren't ready to talk about elder abuse. Jeffers concluded that there was very little knowledge or acknowledged knowledge of elder abuse in the State. One minister who responded to the survey said he wasn't aware of elder abuse and, if he was, he would be too ashamed to admit it. He simply assumed the wounds he sees are the result of falls or are self-inflicted. He feared the elderly would be embarassed by being asked about their injuries.

Mention of the topic of elder abuse began to emerge in the professional literature in the late 1970's, but it wasn't until recently that the public media began to feature articles on the problem. In the late 1970's and early 1980's four regional studies were done and a national survey completed by the U.S. House of Representatives.[77] This survey generated

tentative clues to the typical profile of abused and abuser, as well as providing an initial estimate that one million older Americans were abused each year.

Girard, in his paper entitled Elder Abuse and Its Impact on Hospital Social Work argues that there are two schools of thought about the extent of the problem of elder abuse.

> The first is that to abuse or neglect an incompetent old person is a despicable act and, therefore, a rare event. The second line of thinking is that when people get motivated by money or similar advantages (e.g. free housing), the care of the elderly becomes secondary and taking advantage of the monies accruing to the elder is primary.[78]

It would appear that most Nova Scotians' have little or no real knowledge about the nature and extent of elder abuse. If a public opinion poll were to be taken, it would be safe to assume that the majority of respondents would be unaware of the problem of elder abuse or, if there was any awareness, the conventional wisdom would be that the abuse occurred in institutions, notwithstanding the fact that the bulk of elder abuse takes place in the community.

A number of factors have, no doubt, contributed to the unwillingness and/or inability on the part of the general public to comprehend the nature and extent of elder abuse in the community.

First, seniors living in their own home or the family home of relatives are unwilling or unable, for a variety of reasons, to report neglect or abuse by their caregivers, thus only a fraction of the cases of neglect or abuse receive public

attention.

Second, seniors are adults who have looked after themselves for a lifetime, and most believe that no individual or group has the right to interfere in how an adult chooses to live as long as he/she does not infringe on the rights of others. We live at a time of much sensitivity to and concern for human rights and civil liberties. Government at all levels has become suspect because of perceived undue interference in individual and corporate affairs. Therefore, the government and the community generally are reluctant to get involved in a senior's private life.

Third, non-involvement has become a way of life for many people, partly because of fear of the law and partly because of selfishness. Rathbone-McCuane and Barbara Voyles,[79] writing on the American situation state that crimes in the United States are committed openly with passive onlookers. There are those who suggest that Canadians are becoming very much the same in their outlook and attitudes and the result is a growing public attitude of non-involvement in elder abuse.

Schlesinger, in her article entitled "Granny Bashing" makes a strong plea for a greater public awareness and response to the problem of elder abuse.

> We must be aware of the crime of elderly abuse, and we must begin to initiate programs and attitudes to prevent it. We support rape-crisis centres, we fight to help the battered wife, and we speak out against child abuse in all forms. We fight for quality of life. Why are we silent when our mothers and grandmothers struggle alone and in silence in their battle for survival, for growing old in an atmosphere of dignity and understanding? We

must provide the strength for those who no longer have much strength. We must hear the silent cries, and our voices must help them speak. We too will grow old and we too want to live in a world of mutual respect, love, and care, not increased elderly abuse, not a world of "granny-bashing".80

DETECTION AND INTERVENTION

Rathbone-McCuane and Voigles[81] argue that two major barriers must be overcome if we are to intervene and prevent elder abuse, namely, the denial by professionals that the problem exists and that it is increasing; and, the lack of procedures for case detection. No matter how objectively the topic is presented, the majority of clinicians appear horrified, dismayed and disbelieving. Skilled and experienced clinicians who have extensive experience with violence as a form of uncontrolled aggression or sustained anguishing stress within a family do not seem to promptly recognize abuse of the elderly. This negation of the problem, these authors contend, has hindered knowledge development and intervention efforts.

Rathbone-McCuane[82] sees the key as the private physicians, who are the professionals most frequently in contact with the aged population, willingness to probe the possibility of family conflicts even when made uncomfortable by such discussion. Unless they pick up elder abuse, he argues, the chances are nobody will.

Eastman[83] emphasizes the role of the visiting health nurse in detecting elder abuse.

Floyd, drawing on the work of Galbraith and Zdorkowski, suggests the following questions be pursued in abuse intervention:

- Is there a family history of violent patterns over several generations?
- Does a family member desire to return abuse rendered to him by others?
- Is there evidence of abusive behavior associated with the consumption of intoxicants?
- Do members of the family mutually reinforce the violent behavior of others?
- Does the older person represent a type of dependency for the family unit?
- Do younger family members display a low tolerance for dependency?
- What kind of stresses confront the multigenerational family system?
- Between aged parents and adults, is there a conflict in power and resource distribution?[84]

There are a number of very basic principles that should govern any intervention in cases of old age abuse and these have been outlined by Villamoore and Bergman.[85]

The most fundamental principle of all is the client's right to determine for him or herself whether to accept intervention and help.

The second flows from the first and is that the intervention should be as appropriate and as intensive as the problem(s) require.

The third is that it is very important to keep the family together. Evidence from American old age abuse case histories shows clearly that many families have learned to cope and deal with stress leading to abuse because separation is not offered as the only solution. Unpublished research done by Enid Levin of the National Institute of Social Work has shown

that most families are motivated, despite the stress, to maintain their elderly dependents within the family network.

The fourth follows from the third in that in order to avoid separation by removal, social workers and helping agencies should concentrate on community-based services rather than old people's homes.

Avoidance of blame is the fifth principle which should govern intervention. A professional entering the situation who blames either the abuser or abused will do little to help either restore fractured emotions or to ensure that abuse ceases.

The final principle on which social work should be based is that inadequate or inappropriate intervention may be worse than none at all.

Eastman[86] divides social services intervention into three stages.

Stage 1 focuses on the information the social worker must obtain in initial interviews with clients and caregivers including medical evaluation of client and caregiver, financial situation of the family, family composition, home environment, social support network for both parties and the level of community support services presently being provided to the family.

Stage 2 focuses on the use of the case conference, as a model for planning and evaluating information and intervention. The case conference offers a method of gathering and evaluating information and co-ordinating the functions and responsibilities

of different agencies. The aim of the case conference is to ensure that agencies can work together to provide an effective delivery of service(s) and to provide an ongoing review system.

Stage 3 focuses on follow-up. The key worker's role is fourfold: first, to identify the problems and to review the client's assessment on a regular basis; second, case planning and referral to other agencies; third, service facilitation; and fourth, follow-up on the effectiveness of case conference recommendations between reviews.

The following chart by Eastman summarizes the types of intervention, highlighting the need for a multi-disciplinary approach and, shows how the need should not exclude but rather actively encourage the role of voluntary agencies and self-help groups.

Operational Intervention Chart

Problem	Action	Goal
1 Physical/emotional dependency. (Infirmity, incontinence, etc).	Referral occupational therapist/GP Medical assessment	Increase independence of client/caregiver.
2 Poor communication	Counselling by skilled worker. Speech therapist. Other	Re-establish positive communication to enable clear expression of feelings, guilt, resentment, etc. General improvement of communication skill.
3 Altered life-style of caregiver.	Community support services (eg care assistance scheme, respite care).	Free caregiver of feeling trapped. (See Chapter 4).
4 Role reversal. (As 2 above).	As 2 above.	As 2 above.
5 History of falls. (fractures, etc). Caregiver suffering from "nerves".	Referral to GP/ geriatrician. Medical assessment of both client and care-giver.	Decrease falls/ ascertain reasons for them.
6 Bruising/injury.	As 5 above. Possible police intervention.	Determine cause of injury. Police may take criminal action. Educate caregiver in physical care/skills.
7 Poor housing.	Refer to Housing department Voluntary agency Occupational therapist	Re-housing. Adapt accommodation to the need of dependent/ caregiver.

Clarke,[88] writing on elder abuse aptly describes our present challenge as one of establishing methods of reducing the prevalence of elder abuse and of offering support to care-givers and their elderly dependents and not so much to document its incidence.

O'Malley, Segars and Bergman[89] in their analysis of protective service systems for handling elder abuse cases point out that family violence, whether wife battering, child battering or the battering of elders, is a multi-dimensional problem and its solution must therefore be multi-dimensional in scope. Those who intervene must be able to respond to the social, legal, financial, emotional and medical needs of the abused person. There may also be housing and nutritional deficits which must be addressed. Meeting such needs requires coordinating a variety of service providers as well as developing appropriate service alternatives. This inter-agency, multi-professional response to elder abuse is essential to its resolution.

Equally essential is the need to identify and address the chronic conditions which may have contributed to abuse of the elder. As in child abuse, simply removing the victim from the home until the caregivers cool off, accomplishes little. Counselling, job placement, medical assistance and other services may be required to create a stable home environment in which violence plays no role. Service provision which merely addresses the fact of abuse and not the contributing conditions,

may serve to exacerbate existing tensions within an already deteriorating family structure. Services to the abused person's family are as important as services to the victim in any protective services situation.

A mandated elder abuse reporting law is required which offers protection to the abused individual while insuring the individual's right to privacy and self-determination. Such legislation must be accompanied by a protective services capacity which can provide immediate protection to the victim of abuse; coordinate more long-range responses to the chronic conditions which underlie the violent act; and, provide on-going data on the nature of abuse which will permit the refinement of responses to this serious problem. To the extent possible this protective services capacity should respect the client's rights to self-determination, maintain and support the family support network and encourage the least restrictive alternatives to care.

Any protective services system must have pre-planned individual case responses or protocols which will enable the system and its individual workers to respond quickly and properly to the type of case being confronted, and the capacity for a coordinated, inter-disciplinary response on the part of the service system to both the emergency and the chronic conditions exhibited by these cases.

Workers with elders who are confronted with abuse or suspected abuse must know what their options are in each

situation. Regardless of the emergency or non-emergency nature of the situation, workers must know the service plan options available to them in their community. To the extent that the case is emergency in nature, the worker's ability to respond or arrange for an immediate response is crucial to the safety of the victim.

Communities planning a protective service system for abused elders should set as one of their first tasks the development of protocols for the four basic types of situations with which they will be confronted:

- the client who consents to assessment/service delivery and who appears to be mentally competent;
- the client who refuses assessment/service delivery and who appears to be mentally competent;
- the client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make decisions regarding his/her own care; and,
- the client who is in danger of immediate and grievous bodily harm (emergency cases).

These protocols, and others which will no doubt have to be developed, serve to protect both the client and worker from lax or overzealous reactions and help assure that the worker remains cognizant of the client's right to self-determination.

Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders.

The committee's role would be two-fold:

- to establish linkages between agencies that will permit service coordination to take place in a timely manner, including the development of protocols described above; and,
- to provide an on-going review mechanism for individual cases.

While the services required by individual clients will differ, a protective services network for elders should be able to provide a basic group of core services either through an umbrella agency or through formal agreements between providers.

The protective service worker is the key. Many disciplines and services must be brought together in an abuse case and it is essential that one person be held accountable for managing a given case. Designating specific persons as protective services workers is an important means of assuring the system's accountability to the client. In addition, recent literature shows the importance of a stable and on-going client/worker relationship in successfully dealing with abusive situations.

Once a suspected case of abuse is reported, the system must be able to evaluate the need for services, level of services and the most appropriate response. In a complete protective services system, this assessment capacity is provided through a case assessment team composed of necessary medical, social work and legal expertise.

In addition to the protective service worker, any protective services network will require access to a range of core services including primary health care services; legal services; homemaker/home health aides; respite care; shelter and transportation services; nutrition services,e.g., meals-on-wheels; congregate meals; shopping and cooking; financial assistance; and, police.

Certain elements of any protective services system should be uniform including the following:

°record keeping;

°eligibility guidelines;

°case finding, reporting and referral;

°confidentiality;

°training; and,

°funding.

In this section considerable emphasis has been placed on the role of counselling and support services in addressing elder abuse and the chronic conditions underlying this abuse. The literature on elder abuse is replete with case examples where this approach has enabled a caring family or relatives

to continue to cope with the demanding and frustrating task of caring for an aging family member. The literature does not appear to be nearly as encouraging in those situations where the elder abuse is accompanied by a history of family violence, alcoholism and/or drug abuse. Counselling and support services must be tried but workers in the field should not be discouraged if such an approach is not greatly effective in reversing long entrenched patterns of deviant behaviour.

PROVINCIAL-NATIONAL-INTERNATIONAL CONFERENCES

Considerable attention has been focused on the elderly in the 80's. The World Assembly on Aging (1982), the Canadian Conference on Aging (1983) and the Nova Scotia Conference on Aging and the Aged (1984) focused on ways and means of improving the quality of life for seniors.

While the World Assembly on Aging[90] did not address abuse or neglect of the elderly per se, the documentation emanating from the Assembly highlighted the traditional role of the family as the caretaker of the elderly and stressed the need for training of family members and the development of appropriate support services to caregivers. With the increasing number of women entering the work force in many countries, the whole family, including the male members, will need to share in taking care of its elder members and the planning and provision of community services can make a crucial difference to the willingness and ability of families to continue to care for elder members.

The Canadian Conference on Aging on October 24-27, 1983 included a workshop entitled "Crime and Abuse of the Elderly", which recommended a number of measures to deal with crime and abuse against the elderly including the following:

- That programs and services to create awareness and provide information regarding crimes and abuse of the aged should not be developed in isolation but within existing facilities.

- That less time consuming and less threatening adjudication procedures for aging persons should be established to overcome the rigidity of the court system.

°That by utilizing research and legislation and by providing limited funding,governments should ensure that systems are in place to enable older persons who have great reserves of skill and knowledge to administer action-oriented programs on their own behalf and that of their peers.

°That educational programs started in the schools and aimed at people throughout life should be used to:
(a) develop the attitude that older persons have a duty to help themselves by saving money in their productive years to supplement pension programs;
(b) aid them in becoming knowledgeable about community resources and services or the information needed to enable them to contact such resources and services, so as to relieve their families of the burden of growing care costs and ensure themselves the independence they desire in later life.

°That older people should recognize that they have a duty to learn how to protect themselves and their homes against crime and safety hazards, report abuse and crimes against themselves or neighbours and friends, help in community awareness educational programs, and assume responsibility for themselves and other elderly persons in relation to health hazards due to drug abuse, mixing drugs, over-dosing, or using over-the-counter medications without medical checkups or advice.

°That the whole community should be involved in developing programs to protect itself against crime, with special attention being given to the needs of older citizens living in its environs.

°That educational programs should be developed:
(a) for medical and health personnel to direct their attention towards giving the aged respect and attention to their needs, and to provide special instruction regarding medication and drug-induced problems, the more serious effects older people may experience from illness or accident, and the fears of older people resulting from their vulnerability;
(b) for medical personnel to increase their awareness of abuse of the aged, of services available to aid victims, and of the need to report cases of abuse and assault to the police.

°That the media should be encouraged to use their power, impact, and entertainment capability to participate in information and consciousness-raising programs, such as those set forth above, as an important and rewarding public service.

°That governments at all levels should:
(a) provide leadership and the developmental structures to encourage voluntary services; offer a central source of information to self-help and other voluntary groups; and strengthen their means of monitoring compliance with the law by institutions serving elderly persons;
(b) update and consolidate laws to keep them effective in dealing with new, more sophisticated types of crime and abuse; incorporate new information and technology to make a concerted effort, through consultation and goodwill, to eradicate areas of overlap among the various levels of government; and take a leading role in attitude-changing by producing programs such as Participaction.

°That to ensure care is taken to avoid costly duplication and that the experience and skills of older persons are fully utilized in the development and interpretation of programs and the dissemination of information, the federal and provincial/territorial governments should cooperate in undertaking scientific research programs and actuating improved methods of reporting crime and abuse by age to build a Canada-wide reliable data base for policy, planning and program development, and that the federal government should be responsible for giving leadership and providing the necessary coordination.

°That the use of central registers should be examined with a view to evaluating whether or not they are sufficiently effective to justify their cost and to consider the possibility of developing alternative methods.

°That the definition of abuse as developed by the Work Group be further examined and refined in relation to its use in research.

°That the right of the media to inform should be secondary to the right of private citizens, including vulnerable older people, to protection from crime and violence, and therefore names and addresses of victims of hold-ups and forcible entry should not be reported because there is evidence that this information is used for second attempts.

°That educational programs for persons in all age groups, beginning in the schools should be developed to: effect changes in attitudes and morals, raise awareness of ways to avert danger, create attitudes of helpfulness and support regarding victims of crime or abuse in need of help, alleviate anxieties and enhance physical and psychological security.

°That proposals developed at the conference regarding crime and abuse should be studied by groups and persons at the community level where with aging persons involved in all stages

there should be: effective communication with all concerned, interpretation of the implications of proposals made in relation to perceived needs in the community, setting of priorities for action, and formulation of sound proposals for action by government.

°That municipal governments should be kept fully informed when proposals for action are made to higher levels of government because it is often these local governments which must administer provincial/territorial programs and policies and find the necessary funds to do so.

°That the federal and/or provincial/territorial governments should provide the necessary leadership, encouragement and funds to enable the different groups at the community level to design programs and deliver services that are needed to deal with the problems arising from abuse of, and crime against aging persons.

°That governments at all levels should study the proposals developed at the conference and establish their priorities to deal with the different proposals advanced.

°That future conferences should be held but they should possibly be regional in scope as time allotted to Work Groups at this conference did not allow sufficient time for proper development of ideas.[91]

The Nova Scotia Conference on Aging and the Aged held at St. Francis Xavier University on June 10-12, 1984 and sponsored by the Government of Nova Scotia, included 244 seniors from all regions of the Province. Twelve workshops presented reports for action including one on "Crime and Elder Abuse"[92] which recommended -

°the passage of legislation respecting elder abuse and neglect which is as strong and effective as that governing child abuse and neglect;

°the Secretariat carry out a province-wide study to ascertain the incidence of elder abuse/neglect in the Province;

°more public awareness of services and programs for seniors;

°day hospitals and more day care services;

°the numbers, education, training and attitudes of staff in homes for special care be reviewed to ensure the social and psychological as well as the physical and biological needs of residents are met;

°the Human Rights Act be amended to guard against discrimination of the elderly;

°the medical and pharmaceutical professions be made aware of the amount and types of drugs seniors are taking, in an attempt to ensure better control of such medications;

°that seniors be made aware of scams and rip-offs and practical preventive measures;

°the use of restraints in homes for special care be reviewed to ensure their use is essential; and

°that the Neighborhood Watch Program be implemented in all communities in Nova Scotia to reduce crime against the elderly.

The Senior Citizens' Secretariat in its "Statement on Aging and the Aged" published in the spring of 1984 suggested that a number of initiatives be undertaken in an effort to combat elder abuse including the following:

° A concerted educational program in respect to the nature and extent of elder abuse so that all members of society, particularly human service professionals, become aware of what is happening and what steps might be taken to prevent abuse. The responsibility for this rests with all of us - individual citizens, seniors, seniors' organizations, health professionals, social workers and government.

°Universities and bodies competent to conduct research and fact-finding direct their resources towards determining the nature and extent of elder abuse. This will not be easy but it needs to be done so that we have facts with which to work.

°A brief, well-prepared statement be prepared on the nature and extent of elder abuse and the existing resources available in the community which may be utilized in alleviating abuse. There is much that we could do to alleviate the situation

even now if professionals and the public generally knew the nature and extent of the problem and were aware of the resources available at the moment to cope. We do not yet have this information except in bits and pieces.

°Involve the media to a much greater extent than we have to date. This cannot be achieved unless we have facts at our disposal. The media has done much in the past decade to focus public attention on child abuse. It could also do much to focus attention on the nature and extent of elder abuse.

°More extensive involvement and communication between the police and community organizations concerned with elder abuse and security for the elderly. A major aspect of elder abuse is the growing volume of crimes, for example, purse-snatching. We have already made reference to security and the concerns which all seniors have in respect to their personal safety and well-being. The police can help in this area.

°Programs similar to Neighbourhood Watch be introduced involving young people. We have referred elsewhere in this report to inter-generational programs. Extensive use is being made across Canada of Neighbourhood Watch in respect to security for children. We need similar programs for seniors, and young people could play a most useful role in their development and operation.

°A central registry on elder abuse at the provincial or national level. Such a registry has been used extensively in obtaining information on child abuse, disability and similar social problems.

°At the moment, professionals and others confronted with elder abuse have no mechanism for reporting what is happening. The police may act if the situaiton is serious, but more often than not there are no grounds for prosecution, and most of these incidents, no matter how serious, pass unnoticed. A central registry would not solve the growing problem of elder abuse, but it would enable society to have a clearer understanding of the nature and extent of the problem and thus a greater appreciation of what may be required by way of legislative response.[93]

THE NOVA SCOTIA SCENE

The Province, with the proclamation of "An Act to Provide for the Protection of Adults from Abuse and Neglect"* on January 6, 1986 has taken an essential step in the development of a protective services system for the elderly.

The new Act covers physical abuse, sexual abuse, mental cruelty or a combination thereof and provides a

> means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services which will enhance their ability to care and fend for themselves or which will protect them from abuse or neglect.[94]

An "adult" is defined to include any person apparently sixteen years of age or older and an "adult in need of protection" includes any such person who, in the premises where he/she resides,

> (i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or
>
> (ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention;[95]

Section 5(1) of the Act requires that -

> 5 (1) Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister.[96]

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*See Appendix "A"

Section 5(2) provides that

> (2) No action lies against a person who gives information under subsection (1) unless the giving of the information is done maliciously or without reasonable and probable cause.[97]

Combined with the provisions of other Nova Scotia Statutes, including the Public Trustee Act (which may be used to address financial abuse), the Incompetent Persons Act, the Guardianship Act, and the Criminal Code of Canada, Nova Scotia now provides specific legal remedies for elder abuse and/or neglect.

The Public Trustee Act, Chapter 12 of the Revised Statutes of Nova Scotia of 1973,[98] as amended, provides for the administration of the estate of a person or a deceased person - thus providing a legal remedy for financial abuse of the elderly - but makes no provision for the guardianship of the person. However, the Public Trustee may perform the duties of and be a guardian under the Guardianship Act and the Incompetent Persons Act. The initiative for such action would rest with the Public Trustee and the decision to appoint the Public Trustee as guardian would rest with the appropriate court.

The Attorney General's Department in clarifying the role of the public trustee has provided the following additional information:

> The Public Trustee has capacity and authority under the Public Trustee Act of Nova Scotia to undertake a number of fiduciary roles and, with his consent, may be appointed by the Court to function in a number of representative roles.

> If a guardian is required to manage the estate of an elderly person who, by reason of mental or physical disability, is susceptible to financial abuse, the Public Trustee, in addition to being eligible for appointment as such guardian, may apply to the Court on his own initiative and be appointed as guardian. Thus, the Public Trustee could respond to legitimate objections of any kind of financial abuse to a mentally or physically disabled elderly person and may invoke the Court's assistance in that behalf.
>
> In addition, the Public Trustee may readily become administrator of the estate of a deceased victim of financial abuse and, as such, sue for redress of that abuse when the heir-at-law or testamentary beneficiaries are absent from the Province or neglect or refuse to do so or are, themselves, perpetrators of that abuse.
>
> .....if a mentally competent elder who needs, but has not, a fiduciary or who mistrusts an Attorney or other fiduciary or volunteer who has control of that elder's property, or who is thought to be maneuvering for control by duress or undue influence, the elder can contract with the Public Trustee for management of his property and that contract may be an enduring contract that does not terminate automatically upon the principal becoming mentally incompetent.[99]

The Incompetent Persons Act, Chapter 135 of the Revised Statutes of Nova Scotia of 1967, as amended,[100] provides a vehicle for relief for those elderly persons who are incapable, because of infirmity of mind, of managing their own affairs. Relatives, friends or social agencies, including the Public Trustee, may petition for guardianship of the incompetent person and upon appointment as guardian may take whatever steps are required to ensure the person's well-being. This Act does not apply to elderly persons who are of sound mind but unable for physical or other reasons to care for themselves.

Finally, Section 197 of the Criminal Code delineates the duty of persons to provide necessaries as follows:

> Duty of persons to provide necessaries - Offence - Punishment - Presumptions.
>
> 197. (1) Every one is under a legal duty
> (a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
> (b) as a married person, to provide necessaries of life to his spouse, and 1974-75-76, c. 66, s. 8(1);.
> (c) to provide necessaries of life to a person under lhis charge if that person
> (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and
> (ii) is unable to provide himself with necessaries of life.
>
> (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if
> (a) with respect to a duty imposed by paragraph (1) (a) or (b)
> (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or
> (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or
> (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.[101]

The proclamation of the Adult Protection Act set the scene for the development of a Protective Services System in Nova Scotia. On January 2, 1986, a Co-ordinator of Adult Protection was appointed in the Department of Social Services and this person will develop a province-wide protection services capacity which will provide immediate

protection to the victim(s) of abuse or neglect; co-ordinate more long range responses to the chronic conditions which underlie this abuse and neglect; and, provide ongoing data on the nature of abuse and neglect which will permit the refinement of responses to this serious problem.

Pre-planned individual case responses or protocols which enable the system and individual workers to respond quickly and properly to the type of case being confronted must be developed and the capacity for a co-ordinated, inter-disciplinary response on the part of the service system to both the emergency situation and the chronic condition underlying instances of abuse and neglect must be put in place.

Uniform requirements with respect to record keeping, eligibility guidelines, case finding, reporting and referral, confidentiality and training are being developed.

As indicated earlier, there is general agreement with respect to the core services required by a protective services network. Most of these services, including primary health care services, legal services, homemakers, transportation, nutrition, financial assistance, police, emergency housing, etc. are available, albeit at times on a limited basis, throughout the Province.

Steps are now being taken to employ protective service workers who are the key to any protective services system and to develop case assessment teams involving appropriate representation from health, social services and the legal professions.

At the time the Act was implemented, a number of social work staff in the Province were designated by the Minister of Social Services to have, perform and exercise any of the powers, privileges, duties and functions of the Minister as contained in Sections 6, 7, 10(1) and 15 of the Adult Protection Act. In addition, two new Adult Protection Workers have been approved for the current fiscal year to work out of the Social Service Regional Offices in Sydney and Kentville.

POINTS FOR FURTHER DISCUSSION AND CONSIDERATION

We now have legislation covering elder abuse and neglect. The existing provisions in the Criminal Code, the Incompetent Persons Act, the Public Trustee Act and the Guardianship Act in combination with "The Act to Provide for Protection of Adults from Abuse and Neglect", offer help to those in need of protection. The extent of elder abuse and neglect and any gaps in legislation will only become evident with experience.

The Central Registry has been in use for disabled persons and child abuse for several years. To be truly effective, a Registry must have three facets:

First. The Registry must be kept up to date. Otherwise, its purpose is defeated and the information in it is of little or no value.

Second. The identifying information must be full and complete in respect to the individual and the nature and extent of the abuse.

Third. There has to be effective follow-up treatment by the appropriate personnel, otherwise the Registry becomes little more than a statistics bank with the abuse problems remaining untreated.

There has been and continues to be skepticism about the value of Central Registries because of deficiencies in

all or some of these basic requirements.

If protective legislation is to serve as a positive treatment measure, there would appear to be a useful role for a form of Central Registry.

If there is no Central Registry, the minimum requirement should be some device for storing information on actual and suspected cases of elder abuse. This the Department of Social Services will be doing as it proceeds to implement the new Adult Protective Services legislation.

It has already been recommended that there be developed a concerted educational program in respect to the nature and extent of elder abuse so that all members of society become aware of what is happening and what preventive steps we should be taking.

An educational program should have several facets:

(a) A statement should be prepared on the nature and extent of elder abuse and the existing resources available in the community that may be utilized in alleviating abuse. This publication attempts to address one facet of a required education program.

(b) The media should be involved to a much greater extent than in the past. This would assist in mobilizing public opinion and disseminating information.

(c) Children are being exposed less and less to the

older members of our society. This tends to limit their understanding of the aging process and the role seniors may play in families and the community. What role should the public school be expected to play in developing a curriculum which would help to change attitudes and create awareness of the nature of aging and the appropriate role of the aged in our society? One of the more successful inter-generational initiatives has been undertaken in the City of Dartmouth where the local schools have combined forces with the Senior Citizens' Centre and are making it possible for public school students to respond to senior citizens' need for help with shopping, snow shovelling, recreation, etc. A similar project has been in operation for several years in New Waterford.

(d) Formal education, staff training and development programs should be required for all personnel working with seniors in hospitals, homes for special care, and similar facilities. Continued upgrading of personnel working with the aged is an urgent necessity if we are to cope constructively with elder abuse and neglect.

Care providers such as homemakers and family members involved in caring for the aged also need similar educational opportunities.

(e) The public generally and seniors particularly have limited knowledge of the network of health, welfare, and housing resources available in the community to assist them. This deficiency requires constant attention from both the public and private sector.

One of the most pressing needs at the moment is a more in-depth knowledge of the nature and extent of elder abuse in Nova Scotia. A greater emphasis must be placed on research and fact finding if we hope to design adequate and effective education and protective service programs. A province-wide study along the lines of the one undertaken by Haley is urgently needed.

Government cannot and must not be expected to effectively address elder abuse single handedly. The local community, voluntary organizations, seniors groups and seniors themselves must take an active role. There are over two hundred seniors clubs and councils throughout the Province. These clubs and councils have a broad membership base and this membership is likely to know what is happening at the local level with respect to abuse and/or neglect of seniors. Similarly individual members of the community

and/or voluntary organizations are in a prime position to identify possible abuse or neglect situations in their neighbourhoods and communities.

The auxiliaries and advisory committees of local seniors' clubs and councils working with the administration of nursing homes and homes for the aged can do much to lessen the possibility of elder abuse in institutions. We must return to the concept that we are individually and collectively "our brother's keeper".

Older persons have a duty and responsibility to help themselves by saving money in their younger productive years to develop and supplement pension programs.

Seniors have an obligation and responsibility to learn how to protect themselves individually and collectively against crime and safety hazards. There are a variety of ways by which this may be done. Programs such as Neighbourhood Watch and Postal Alert have proven effective. Seniors clubs need to be more imaginative and creative in making use of intergenerational programs so that the energy and willingness of youth is utilized in coping with this problem.

Here and there police departments and individual police officers are involved in educational programs relating to street crimes against seniors. Unfortunately the public are reluctant to visualize the police in a preventive and educational role although experience suggests

police departments can be most helpful in creating a preventive approach to this problem. Seniors clubs and organizations need to do much more in enlisting the help and cooperation of the police in combatting street crimes and house break-ins aimed at seniors.

The Antigonish Conference of June 10, 11 and 12, 1984 recommended that a public attorney be appointed to whom all those having power of attorney would be financially accountable at least annually. The practicality of this recommendation would depend greatly on having these duties attached to some appropriate official in the public service rather than having to create a new position with the attendant costs.

Obviously, the development of province-wide programs such as respite care would do much to relieve the pressure on families caring for their senior members. This, in turn, would help to lessen elder abuse in the home care situations. More extensive availability and use of homemakers and home life supports would have the same beneficial effect.

The Antigonish Conference recommended that the Human Rights Act be amended to include senior citizens as a special group in respect to discrimination.

The issue of financial abuse of seniors is subtle and, if that is possible, even more difficult to control or manage than physical and mental abuse.

However, where because of mental or physical disability the senior may be susceptible to financial abuse, there may be a need for intervention on the senior's behalf. The statement from the Department of the Attorney General referred to earlier should be helpful in dealing with the financial abuse of the elderly. Persons suspecting financial abuse of the elderly should address their concern to the Department of Social Services which may, if circumstances so warrant, involve the Public Trustee who has been advised by copy of the contents of the Attorney General's letter of February 27, 1985. The one major remaining hurdle that must be overcome if the Public Trustee is to fully carry out the intent of the Public Trustee Act relates to additional staff resources.

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APPENDIX "A"

BILL NO. 61

Government Bill

1st Session, 54th General Assembly
Nova Scotia
34 Elizabeth II, 1985

An Act to Provide for Protection of Adults from Abuse and Neglect

CHAPTER 2
ACTS OF 1985

The Honourable Edmund L. Morris
Minister of Social Services

AS ASSENTED TO BY THE LIEUTENANT GOVERNOR
17TH MAY, 1985

Halifax
Printed by Queen's Printer for Nova Scotia

BILL NO. 61 1985

An Act to Provide for Protection of Adults from Abuse and Neglect

Be it enacted by the Governor and Assembly as follows:

1 This Act may be cited as the Adult Protection Act.

2 The purpose of this Act is to provide a means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services which will enhance their ability to care and fend for themselves or which will protect them from abuse or neglect.

3 In this Act,

(a) "adult" means a person who is or is apparently sixteen years of age or older;

(b) "adult in need of protection" means an adult who, in the premises where he resides,

(i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or

(ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention;

(c) "Co-ordinator" means the Co-ordinator of Adult Protection Services appointed pursuant to this Act;

(d) "court" means the Family Court;

(e) "Minister" means the Minister of Social Services;

(f) "prescribed" means prescribed by the regulations;

(g) "regulations" means the regulations made pursuant to this Act.

4 (1) The Minister is charged with the general administration of this Act and may from time to time designate in writing the Co-ordinator or any other person to have, perform and exercise any of the powers, privileges, duties and functions of the Minister or the Co-ordinator under this Act, and shall, when so designating, specify the powers, privileges, duties and functions to be had, performed and exercised by the person so designated.

(2) Where a designation is made pursuant to subsection (1) and the person designated signs or executes a document pursuant to the designation, he shall refer to the name of his office together with the words "Authorized pursuant to Section 4 of the Adult Protection Act" and where a document contains such reference, the document

(a) shall be received in evidence without further proof of the authority of the person who signs or executes the same; and

(b) may be relied upon by the person to whom the document is directed or given and by all other persons as an effective exercise of the power or function to which the document relates.

(3) A Co-ordinator of Adult Protection Services may be appointed in accordance with the Civil Service Act.

5 (1) Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister.

(2) No action lies against a person who gives information under subsection (1) unless the giving of the information is done maliciously or without reasonable and probable cause.

6 Where the Minister receives a report that a person is an adult in need of protection, he shall

(a) make inquiries with respect to the matter; and

(b) if he finds there are reasonable and probable grounds to believe the adult is in need of protection, cause an assessment to be made,

and the Minister may, if he deems it advisable, request a qualified medical practitioner to assess the adult, the care and attention the adult is receiving and whether the adult has been abused.

7 Where, after an assessment, the Minister is satisfied that a person is an adult in need of protection, the Minister shall assist the person, if the person is willing to accept the assistance, in obtaining services which will enhance the ability of the person to care and fend adequately for himself or will protect the person from abuse or neglect.

8 Where the adult who is being assessed refuses to consent to the assessment or a member of the family of the adult or any person having care or control of the adult interferes with or obstructs the assessment in any way, the Minister may apply to the court for an order authorizing the entry into any building or place by a peace officer, the Minister, a qualified medical practitioner or any person named in the order for the purpose of making the assessment, and where

(a) the Minister has given at least four days notice of the hearing to the adult or the person having care or control of the adult; or

(b) the Minister has applied ex parte and the court is satisfied there are reasonable and probable grounds to believe that the person who is being assessed is in danger,

the court may grant the order after making due inquiry and being satisfied that there are reasonable and probable grounds to believe that the person who is being assessed is an adult in need of protection.

9 (1) Where on the basis of an assessment made pursuant to this Act the Minister is satisfied that there are reasonable and probable grounds to believe a person is an adult in need of protection, he may apply to a court for an order declaring the person to be an adult in need of protection and, where applicable, a protective intervention order.

(2) The Minister shall give at least ten days notice of the application in the prescribed form to the person in respect of whom the application is made or some person having custody or control of that person and, where applicable, the person against whom a protective intervention order may be made.

(3) Where the court finds, upon the hearing of the application, that a person is an adult in need of protection and either

(a) is not mentally competent to decide whether or not to accept the assistance of the Minister; or

(b) is refusing the assistance by reason of duress,

the court shall so declare and may, where it appears to the court to be in the best interest of that person,

(c) make an order authorizing the Minister to provide the adult with services, including placement in a facility approved by the Minister, which will enhance the ability of the adult to care and fend adequately for himself or which will protect the adult from abuse or neglect;

(d) make a protective intervention order directed to any person who, in the opinion of the court, is a source of danger to the adult in need of protection

(i) requiring that person to leave the premises where the adult in need of protection resides unless that person is the owner or lessee of the premises,

(ii) prohibiting or limiting that person from contact or association with the adult in need of protection,

(iii) requiring that person to pay maintenance for the adult in need of protection in the same manner and to the same extent as that person could be required to pay pursuant to the Family Maintenance Act.

(4) Where a court makes an order pursuant to clause (c) or (d) of subsection (3), it may advise the Public Trustee that there appears to be no guardian to act on behalf of the adult in need of protection or that it appears that there is a guardian or a person acting pursuant to a power of attorney who is neglecting or dealing with the estate contrary to the best interests of the adult in need of protection.

(5) An order made pursuant to subsection (3) expires six months after it is made.

(6) An application to vary, renew or terminate an order made pursuant to subsection (3) may be made by the Minister, the adult in need of protection or an interested person on his behalf, or a person named in a protective intervention order upon notice of at least ten days to the parties affected which notice may not be given in respect of a protective intervention order earlier than three months after the date of the order.

(7) An order made pursuant to subsection (3) may be varied, renewed or terminated by the court where the court is satisfied that it is in the best interests of the adult in need of protection.

(8) A renewal order expires six months after it is made.

(9) The determination of all matters by a court pursuant to this Section shall be made on the balance of probabilities.

(10) An order made pursuant to this Section may be appealed in accordance with the Summary Proceedings Act and on appeal the order may be confirmed, with or without modification, terminated or remitted with direction to the court appealed from, or another order authorized by this Act may be substituted.

10 (1) Where on the basis of an assessment made pursuant to this Act the Minister is satisfied that there are reasonable and probable grounds to believe that

(a) the life of a person is in danger;

(b) the person is an adult in need of protection; and

(c) the person is not mentally competent to decide whether or not to accept the assistance of the Minister or is refusing the assistance by reason of duress,

the Minister may authorize the immediate removal of the person to such place as the Minister considers fit and proper for the protection of the person and the preservation of his life, and a person so authorized may take reasonable measures to remove the person whose life is in danger.

(2) Within five days after a person is removed pursuant to subsection (1), the Minister shall apply to the court for an order declaring that the person is an adult in need of protection unless the person is sooner returned.

(3) Prior to the hearing of an application pursuant to subsection (2), the Minister shall give notice of the application in the prescribed form to the person in respect of whom the application is made or some person having custody or control of that person.

(4) The court shall proceed forthwith to hear the application of the Minister.

(5) Upon the completion of the hearing, the court may

(a) dismiss the application and direct the return of the person removed; or

(b) make an order in accordance with subsection (3) of Section 9.

(6) Subsections (4) to (10) of Section 9 apply mutatis mutandis to an order made pursuant to this Section.

11 Costs may be awarded against the Minister in the discretion of the court dismissing an application by the Minister pursuant to this Act and the amount shall be determined in accordance with the rules of the Family Court.

12 In any proceeding taken pursuant to this Act the court or judge shall apply the principle that the welfare of the adult in need of protection is the paramount consideration.

13 (1) Where an adult is removed from the premises where he resides to another place pursuant to this Act and it appears to the Minister that there is an immediate danger of loss of, or damage to, any property of his by reason of his temporary or permanent inability to deal with the property, and that no other suitable arrangements have been made or are being made for the purpose, the Minister shall inform the Public Trustee.

(2) Where the Public Trustee receives information pursuant to subsection (1) and where he is of the opinion that his intervention is appropriate, the Public Trustee may assume immediate management of the estate of that person and may take possession of the property of that person and shall safely keep, preserve and protect the same until

(a) the Public Trustee determines that it is no longer necessary to manage the estate of the person;

(b) the Supreme Court or a Judge thereof has appointed the Public Trustee or another person to be guardian of the estate of the adult in need of protection;

(c) a court finds that the person is not an adult in need of protection; or

(d) the order that a person is an adult in need of protection expires, terminates or is rescinded.

14 (1) Nothing in this Act limits a remedy available or affects an action that may be taken pursuant to another enactment.

(2) Nothing in this Act limits or affects the responsibility of a municipal unit pursuant to the provisions of the Social Assistance Act or the obligation of a person to provide maintenance.

15 A peace officer shall assist with the execution of an order issued pursuant to this Act or with the conveyance of an adult in need of protection to a place directed in accordance with this Act when requested to do so by a person acting for the Minister or pursuant to an order of the court.

16 (1) Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection and who fails to report that information to the Minister is guilty of an offence under this Act.

(2) A prosecution for an offence referred to in this Section shall be commenced within one year after the day on which the offence was committed and not thereafter.

17 Every person who violates this Act or a protective intervention order is guilty of an offence punishable on summary conviction and is liable to a fine of

not more than one thousand dollars or to imprisonment for not more than one year, or both.

18 The Family Court has exclusive original jurisdiction over offences against this Act.

19 (1) The Governor in Council may make regulations

(a) respecting the provision of services for adults in need of protection;

(b) respecting the procedure for an assessment pursuant to this Act;

(c) respecting forms to be used pursuant to this Act;

(d) respecting the contents and service of documents to be used pursuant to this Act;

(e) defining any word or expression used in this Act and not defined herein;

(f) respecting any matter necessary or advisable to carry out effectively the intent and purposes of this Act.

(2) The exercise by the Governor in Council of the authority contained in subsection (1) shall be regulations within the meaning of the Regulations Act.

20 This Act comes into force on and not before such day as the Governor in Council orders and declares by proclamation.

Other Secretariat Publications

- Programs for Seniors (3rd Edition) - 1985
- Statements on Aging and the Aged - 1984
- "Seniors Helping Seniors" Proceedings of a Nova Scotia Conference on Aging and the Aged - 1984
- Monthly Newsletter
- Aging and the Aged in Nova Scotia (A list of Writings from 1979 to 1985)